

**Return of Certain Excise Taxes Under  
Chapter 43 of the Internal Revenue Code**

(Under sections 4980B, 4980D, 4980E, and 4980G)

OMB No. 1545-2148

Filer tax year beginning , and ending ,	
<b>A</b> Name of filer (see instructions)	<b>B</b> Filer's employer identification number (EIN)
Number, street, and room or suite no. (If a P.O. box, see instructions)	
City or town, state, and ZIP code	<b>E</b> Plan sponsor's EIN
<b>C</b> Name of plan	<b>F</b> Plan year ending (MM/DD/YYYY)
<b>D</b> Name and address of plan sponsor	<b>G</b> Plan number

**Part I Tax on Failure To Satisfy Continuation Coverage Requirements Under Section 4980B**

Complete a separate Part I, lines 1 through 6 for failures due to reasonable cause and not to willful neglect, and a separate Part I, lines 12 through 14, for other failures, for each qualifying event for which one or more failures to satisfy continuation coverage requirements that occurred during the reporting period (see instructions).

**Section A – Failures Due to Reasonable Cause and Not to Willful Neglect**

<b>1</b> Enter the total number of days of noncompliance in the reporting period . . . . .	<b>1</b>	
<b>2</b> Enter the number of qualified beneficiaries for which a failure occurred as a result of this qualifying event . . . . . <b>2</b>		
<b>3</b> If you entered 2 or more on line 2, multiply line 1 by \$200. Otherwise, multiply line 1 by \$100 .	<b>3</b>	
<b>4</b> If the failure was not discovered despite exercising reasonable diligence or was corrected within the correction period and was due to reasonable cause, enter -0- here, and then go to line 5. Otherwise, enter the amount from line 3 on line 6 and go to line 7 . . . . .	<b>4</b>	
<b>5</b> If the failure was not corrected before the date a notice of examination of income tax liability was sent to the employer and the failure continued during the examination period, multiply \$2,500 by the number of qualified beneficiaries for whom one or more failures occurred (multiply by \$15,000 to the extent the violations were more than <i>de minimis</i> for a qualified beneficiary). If the failures were corrected before the day a notice of examination was sent, enter -0- . . . . .	<b>5</b>	
<b>6</b> Enter the smaller of line 3 or line 5 . . . . .	<b>6</b>	
<b>7</b> If there was more than one qualifying event, add the amounts shown on line 6 of all forms, and enter the total on a single "summary" form. Otherwise, enter the amount from line 6 above . .	<b>7</b>	
<b>8</b> Enter the aggregate amount paid or incurred during the preceding tax year for a single employer group health plan or the amount paid or incurred during the current tax year for a multiemployer health plan to provide medical care . . . . . <b>8</b>		
<b>9</b> Multiply line 8 by 10% (.10) . . . . .	<b>9</b>	
<b>10</b> Amount from section 4980B(c)(4) . . . . .	<b>10</b>	500,000
<b>11</b> Enter the smallest of lines 7, 9, or 10. For a third-party administrator, HMO, or insurance company, the amount you enter on this line filed for all plans you administer during the same tax year cannot exceed \$2 million; reduce the amount you would otherwise enter on this line to the extent the amount for all plans would exceed this limit . . . . .	<b>11</b>	

**Section B – Failures Due to Willful Neglect or Otherwise Not Due to Reasonable Cause**

<b>12</b> Enter the total number of days of noncompliance in the reporting period . . . . .	<b>12</b>	
<b>13</b> Enter the number of qualified beneficiaries for which a failure occurred as a result of this qualifying event . . . . . <b>13</b>		
<b>14</b> If you entered 2 or more on line 13, multiply line 12 by \$200. Otherwise, multiply line 12 by \$100	<b>14</b>	
<b>15</b> If there was more than one qualifying event, add the amounts shown on line 14 of all forms, and enter the total on a single "summary" form. Otherwise, enter the amount from line 14 above .	<b>15</b>	

**Section C – Total Tax Due Under Section 4980B**

<b>16</b> Add lines 11 and 15 . . . . . ►	<b>16</b>	
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Name of filer:

Filer's EIN:

**Part II Tax on Failure To Meet Portability, Access, and Renewability Requirements Under Section 4980D**

Complete a separate Part II, lines 17 through 23, for failures due to reasonable cause and not to willful neglect, and a separate Part II, lines 29-32, for other failures to meet certain group health plan requirements that occurred during the reporting period (see instructions).

**Section A – Failures Due to Reasonable Cause and Not to Willful Neglect**

17	Enter the total number of days of noncompliance in the reporting period . . . . .	17	
18	Enter the number of individuals to whom the failure applies . . . . .	18	
19	Multiply line 17 by line 18 . . . . .	19	
20	Multiply line 19 by \$100 . . . . .	20	
21	If the failure was not discovered despite exercising reasonable diligence or was corrected within the correction period and was due to reasonable cause, enter -0- here, and then go to line 22. Otherwise, enter the amount from line 20 on line 23 and go to line 24 . . . . .	21	
22	If the failure was not corrected before the date a notice of examination of income tax liability was sent to the employer and the failure continued during the examination period, multiply \$2,500 by the number of qualified beneficiaries for whom one or more failures occurred (multiply by \$15,000 to the extent the violations were more than <i>de minimis</i> for a qualified beneficiary). If the failures were corrected before the day a notice of examination was sent, enter -0- . . . . .	22	
23	Enter the smaller of line 20 or line 22 . . . . .	23	
24	If there was more than one failure, add the amounts shown on line 23 of all forms, and enter the total on a single "summary" form. Otherwise, enter the amount from line 23 above . . . . .	24	
25	Enter the aggregate amount paid or incurred during the preceding tax year for a single employer group health plan or the amount paid or incurred during the current tax year for a multiemployer health plan to provide medical care . . . . .	25	
26	Multiply line 25 by 10% (.10) . . . . .	26	
27	Amount from section 4980D(c)(3) . . . . .	27	500,000
28	Enter the smallest of lines 24, 26, or 27. . . . .	28	

**Section B – Failures Due to Willful Neglect or Otherwise Not Due to Reasonable Cause**

29	Enter the total number of days of noncompliance in the reporting period . . . . .	29	
30	Enter the number of individuals to whom the failure applies . . . . .	30	
31	Multiply line 29 by line 30 . . . . .	31	
32	Multiply line 31 by \$100 . . . . .	32	
33	If there was more than one failure, add the amounts shown on line 32 of all forms, and enter the total on a single "summary" form. Otherwise, enter the amount from line 32 above . . . . .	33	

**Section C – Total Tax Due Under Section 4980D**

34	Add lines 28 and 33 . . . . .	34	
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**Part III Tax on Failure To Make Comparable Archer MSA Contributions Under Section 4980E**

35	Aggregate amount contributed to Archer MSAs of employees within calendar year . . . . .	35	
36	Total tax due under section 4980E. Multiply line 35 by 35% (.35) . . . . .	36	

**Part IV Tax on Failure To Make Comparable HSA Contributions Under Section 4980G**

37	Aggregate amount contributed to HSAs of employees within calendar year . . . . .	37	
38	Total tax due under section 4980G. Multiply line 37 by 35% (.35) . . . . .	38	

**Part V Tax Due or Overpayment**



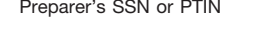
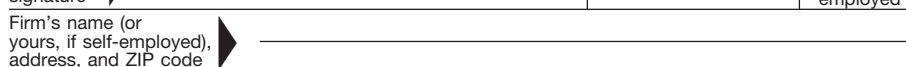
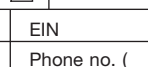
39	Add lines 16, 34, 36, and 38 . . . . .	39	
40	Enter amount of tax paid with Form 7004 . . . . .	40	
41	<b>Tax due.</b> Subtract line 40 from line 39. If less than zero, enter -0-, and go to line 42. If the result is greater than zero, enter here and attach a check or money order payable to "United States Treasury." Write your name, identifying number, plan number, and "Form 8928" on your payment . . . . .	41	
42	<b>Overpayment.</b> Subtract line 39 from line 40 . . . . .	42	

**Sign Here**

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

 Your signature
  Telephone number
  Date

**Paid Preparer's Use Only**

Preparer's signature 	Date 	Check if self-employed <input type="checkbox"/>	Preparer's SSN or PTIN 
Firm's name (or yours, if self-employed), address, and ZIP code 	EIN 	Phone no. ( ) 